United Nations A/66/327

General Assembly

Distr.: General
7 September 2011

Original: English

Sixty-sixth session
Item 140 of the provisional agenda*
Joint Inspection Unit

Review of the medical service in the United Nations system

Note by the Secretary-General

The Secretary-General has the honour to transmit to the members of the General Assembly the report of the Joint Inspection Unit entitled "Review of the Medical Service in the United Nations system" (JIU/REP/2011/1).

* A/66/150.

11-48830 (E) 220911

Please recycle

JIU/REP/2011/XX

REVIEW OF THE MEDICAL SERVICE IN THE UNITED NATIONS SYSTEM

Prepared by

Nikolay Chulkov

Joint Inspection Unit

Geneva 2011

United Nations

JIU/REP/2011/XX

Original: ENGLISH

REVIEW OF THE MEDICAL SERVICE IN THE UNITED NATIONS SYSTEM

Prepared by

Nikolay Chulkov

Joint Inspection Unit

United Nations, Geneva 2011

EXECUTIVE SUMMARY

Review of the medical service in the United Nations system
JIU/REP/2011/XX

This system-wide review assesses the manner in which medical services are provided, managed, supported and monitored, with a view to proposing improvements that will enable the United Nations to meet its duty of care regarding the health and safety of staff. This is of particular importance when considered in the context of the United Nations strategic movement towards mobility and increased field presence and of particular relevance to those staff deployed at hardship duty stations.

The report considers the mandate of the United Nations Chief Medical Director and the Medical Services Division (MSD), as specified in ST/SGB/2004/8, and concludes that in the light of the High-Level Committee on Management (HLCM) recommendation on Occupational Safety and Health (OSH), the Secretary-General modify the mandate/role of MSD. One key feature of OSH, and in particular that of OSH medical services, is that such services should remain independent from other administrative/organizational units and report either directly to the CEO or his/her appointed representative. This implies that OSH medical services, while working in close collaboration with human resources, must not report to them directly.

The adoption of OSH policies by United Nations system organizations will necessitate a paradigm shift in the provision of medical services. It will also lead to cost-efficiencies. Emphasis is now placed on prevention rather than cure. As stated by a former Secretary-General of the United Nations, "... **staff are this Organization's greatest asset. We must treat them as such.**"

The report, while describing the medical services and programmes provided at headquarter duty stations, focuses on medical services in the field as the latter are deemed to be inadequate. It then describes the function of the respective service providers and their interaction with MSD, the United Nations Medical Directors Working Group (UNMDWG) and the United Nations Department of Safety and Security and demonstrates the need to improve overall coordination of system-wide medical services. The issue of accountability in field medical services is raised as while MSD is the "technical supervisor," it has no input on budgets and work plans of field units as well as in the performance management process of the other service providers. Furthermore, United Nations dispensaries are now "managed", on the basis of a draft Terms of Reference prepared by the United Nations Development Programme, by the respective Resident Representatives/Country Teams. This decentralization has led to the accountability issues and difficulties in overcoming disagreements on cost-sharing by the various agencies using the facilities.

An overview of the existing system-wide/inter-agency bodies that coordinate/cooperate on medical/OSH issues is presented. To facilitate the implementation of OSH policies and ensure coordination, the report concludes with a call for the establishment of a system-wide network for OSH issues (including medical services), modelled on the current Inter-Agency Security Management Network for security issues. The proposed new coordinating body would monitor the implementation of United Nations OSH policies, practices and procedures and thereby support HLCM in its comprehensive review of issues pertaining to the entire United Nations occupational safety and health structure.

The United Nations has invested considerable resources in employing a large number of healthcare personnel across the system, but has not yet created the structures required to oversee and manage these resources according to modern healthcare standards.

The review contains 7 recommendations of which 2 are addressed to legislative bodies and reproduced below:

Recommendation 2

The legislative bodies of United Nations system organizations should, while taking account of and compatible with emerging modifications to the Minimum Operating Safety and Security Standards, adopt appropriate standards for Occupational Safety and Health issues.

Recommendation 7

The General Assembly should mandate the Secretary-General to create the United Nations Network on Occupational Safety and Health with a defined Term of Reference, and which should be headed by the United Nations Chief Medical Director.

CONTENTS

			Page
	EXECUTIVE SUMMARY		4
	ABBREVIATIONS		7
	Chapter	*Paragraphs*	
I.	**INTRODUCTION**	1-13	9
	Methodology	7-13	9
II.	**OCCUPATIONAL SAFETY AND HEALTH**	14-26	11
	OSH Implementation	22-26	12
III.	**MEDICAL SERVICES IN THE UNITED NATIONS SYSTEM**	27-75	16
	A. Medical Directors – Post Levels	33-34	18
	B. Staff Member Medical Records	35-37	19
	C. Financing of Medical Services	38-40	20
	D. Medical Services in the Field	41-47	21
	E. Field Medical Service Providers	48-67	22
	- United Nations Medical Services Division	49-54	23
	- United Nations Examining Physicians	55-58	25
	- Department of Peacekeeping Operations	59-60	25
	- Medical Services Support – Department of Field Services	61-62	27
	- Critical Incident Stress Management Unit	63-65	27
	- United Nations Field Medical Services Staff	66-67	28
	F. "Deep Field"	68-69	30
	G. Case Study Liberia	70-75	30
IV.	**CURRENT SYSTEM-WIDE MEDICAL SERVICE COORDINATION/ COOPERATION**	76-95	32
	A. United Nations Medical Directors Working Group (UNMDWG)	76-81	32
	B. United Nations Staff/Stress Counsellors Special Interest Group (UNSSCG)	82-85	33
	C. Critical Incident Stress Working Group (CISWG)	86-88	33
	D. UN Cares	89-92	34
	E. UN Plus	93-95	35
V.	**TOWARDS A FUTURE SYSTEM-WIDE MEDICAL SERVICE/ OCCUPATIONAL SAFETY AND HEALTH COORDINATION/ COOPERATION MECHANISM**	96-111	36

ANNEXES

I.	Medical Services and Programmes Provided at headquarter duty stations (as of June 2010)	40
II.	Services generally expected from on-site United Nations dispensaries	41
III.	Glossary of Level 1-4 United Nations Medical Facilities	43
IV.	Medical Support Section core functions	45
V.	Overview of action to be taken by participating organizations on JIU recommendations	47

LIST OF TABLES

1.	Representative Components and Outputs of an Organizational Safety and Health Programme	12
2.	Grades of Medical Chiefs (headquarters) (as of June 2010)	18
3.	Availability of Staff Member Medical Records in electronic format (as of June 2010)	19

ABBREVIATIONS

ACABQ	Advisory Committee on Administrative and Budgetary Questions
ACC	Administrative Committee on Coordination
CEB	United Nations System Chief Executives Board for Coordination
CEO	Chief Executive Officer
COE	Contingent Owned Equipment
CISMU	Critical Incident Stress Management Unit
CISWG	Critical Incident Stress Working Group
CTBTO	Comprehensive Test Ban Treaty Organization
DFS	Department of Field Support
DPA	Department of Political Affairs
DPKO	Department of Peacekeeping Operations
ECA	Economic Commission for Africa
ECE	Economic Commission for Europe
ECLAC	Economic Commission for Latin America and the Caribbean
ERP	Enterprise Resources Planning
ESCAP	Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
FAO	Food and Agriculture Organization of the United Nations
FMT	Forward Medical Teams
HLCM	High-Level Committee on Management of the CEB
HRN	Human Resources Network
IAEA	International Atomic Energy Agency
IASMN	Inter-Agency Security Management Network
ICAO	International Civil Aviation Organization
ILO	International Labour Organization
IMO	International Maritime Organization
INFM	Inter-Agency Network for Facilities Management
IOM	International Organization of Migration
ITC	International Trade Centre
ICTR	International Criminal Tribunal for Rwanda
ITU	International Telecommunication Union
JIU	Joint Inspection Unit of the United Nations system
LOA	Letter of Agreement
LSD	Logistics Support Division
MOSS	Minimum Operating Safety and Security Standards
MOU	Memorandum of Understanding
MSD	Medical Services Division
MSS	Medical Support Section
MSU	Medical Support Unit
OIOS	United Nations Office for Internal Oversight Services
OPCW	Organization for the Prohibition of Chemical Weapons
OPS	Office of Planning and Support
OSH	Occupational Safety and Health
PCC	Police Contributing Countries
PHTLS	Pre-Hospital Trauma and Life Support
SSS	Specialist Support Section
TCC	Troop Contributing Countries
TOR	Terms of Reference

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNDSS	United Nations Department of Safety and Security
UNEP	United Nations Environment Programme
UNEPS	Unites Nations Examination Physicians
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNHQ	United Nations Headquarters
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNMDWG	United Nations Medical Directors Working Group
UNMIL	United Nations Mission in Liberia
UNNOSH	United Nations Network on Occupational Safety and Health
UNODC	United Nations Office on Drugs and Crime
UNOG	United Nations Office at Geneva
UNON	United Nations Office at Nairobi
UNOV	United Nations Office at Vienna
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSECOORD	United Nations Security Coordinator
UNSIC	United Nations System Influenza Coordination
UNSSCG	United Nations Staff/Stress Counsellors Special Interest Group
UNV	United Nations Volunteers
UNWTO	World Tourism Organization of the United Nations
UPU	Universal Postal Union
VIC	Vienna International Centre
WFP	World Food Programme
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WMO	World Meteorological Organization

I. INTRODUCTION

1. As part of its programme of work for 2010, the Joint Inspection Unit (JIU) conducted a review entitled "Review of the medical service in the United Nations system" from February to November 2010, based on proposals submitted by the United Nations/Office of Human Resources Management/Medical Services Division and the Office of Internal Oversight Services (OIOS).

2. This system-wide review assesses the manner in which medical services are provided, managed, supported and monitored, with a view to proposing improvements that will enable the United Nations to meet its duty of care regarding the health and safety of staff. This is of particular importance when considered in the context of the United Nations strategic movement towards mobility and increased field presence and of particular relevance to those staff deployed at hardship duty stations. As stated by a former Secretary-General of the United Nations, "... **staff are this Organization's greatest asset. We must treat them as such.**"[1]

3. The scope of the report does not include medical insurances issues, as that had been dealt with in a previous JIU report,[2] nor the quality of care (medical treatment) provided by United Nations medical staff. It also does not delve into the subject of sick leave management, as the latter will most likely be the topic, as it was requested by a number of United Nations system organizations, of a forthcoming JIU review.

4. As the High-Level Committee on Management (HLCM) of the Chief Executives Board for Coordination (CEB) endorsed the proposal submitted by the United Nations Medical Directors Working Group (UNMDWG) for the adoption of an Occupational Safety and Health (OSH) policy[3] and recommended all organizations to adopt an individual OSH policy respectively,[4] this report will further elaborate on the implications therein.

5. **The adoption of OSH policies by United Nations system organizations will necessitate a paradigm shift in the provision of medical services. Emphasis is now placed on prevention rather than cure.**[5] The next chapter describes what this shift entails. Chapter III will, for background purposes, describe the current medical services provided at both headquarter and field duty stations, cognizant of the fact that there will be an organizational/managerial change thus rendering to some extent, a detailed analysis of current practice, a limited exercise.

6. The report will then provide an overview of the current system-wide bodies that either cooperate on or coordinate health issues and finally call for the establishment of a system-wide mechanism to monitor and manage OSH.

Methodology

7. In accordance with the internal standards and guidelines of JIU, the methodology followed in preparing this report included a detailed desk review, questionnaires, interviews and in-depth analysis.

8. The Inspector, through interviews in person and by tele/videoconferences as well as onsite visits to United Nations medical facilities, sought the views of many medical service staff as well as officials from human resources and finance within the United Nations system organizations in

[1] http://www.un.org/News/Press/docs/2006/sgsm10705.

[2] (JIU/REP/2007/2) "United Nations system staff medical coverage".

[3] "Occupational Health and Safety Policy in the UN System – Submission of the UN Medical Directors Working Group", CEB/2010/HLCM/11, 11 February 2010.

[4] CEB/HLCM/2009/HLCM/32.

[5] CEB/2010/3, para 77, p.14.

various duty stations as well as UNMDWG member organizations. The Inspector also visited Department of Peacekeeping Operations (DPKO) medical facilities in Lebanon and Liberia. In addition, close collaboration was maintained between the Inspector and the UNMDWG steering committee members at various stages of the project.

9. The Inspector was invited to present his preliminary findings, based on the responses received to his questionnaires, at the UNMDWG annual meeting in Geneva, Switzerland, hosted by the International Labour Organization (ILO) in October 2010. After the presentation, the participants discussed at length the emerging findings and possible recommendations.

10. Comments on the draft report from all the United Nations system organizations and those UNMDWG members who responded to the questionnaire were sought and taken into account in finalizing the report.

11. In accordance with article 11.2 of the JIU statute, this report has been finalized after consultation among the Inspectors so as to test its conclusions and recommendations against the collective wisdom of the Unit.

12. To facilitate the handling of the report, the implementation of its recommendations and the monitoring thereof, Annex V contains a table indicating whether the report is submitted to the organizations concerned for action or for information. The table identifies those recommendations relevant for each organization, specifying whether they require a decision by the organization's legislative or governing body or can be acted upon by the organization's executive head.

13. The Inspector wishes to express his appreciation to all who assisted him in the preparation of this report, and particularly to those who participated in the interviews and provided responses to the questionnaires and so willingly shared their knowledge and expertise.

II. OCCUPATIONAL SAFETY AND HEALTH

14. The International Labour Organization (ILO) Occupational Health Services Convention (No. 161) defines "occupational health services" as services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking on the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health.

15. The manner in which such health services are provided is stated in an organization's occupational safety and health (OSH) policy, made by the Chief Executive Officer (CEO) of an organization. A written policy provides the framework from which an effective OSH programme can be implemented. An OSH policy statement should be concise and provides the mandate and allocates specific resources to health and safety activities. This policy should be updated regularly.

16. The implementation of an OSH policy is usually done through a manual (administrative instruction). While the content/structure may vary, there are certain common features, as specified below.

17. Responsibility and accountability: OSH is a responsibility which starts at the highest organizational level and passes down through the line management chain to all supervisors. Employees are nevertheless responsible for their own health and safety and for implementing their organization's OSH guidelines. It must be noted that it is **not** the Medical Service or OSH service that is responsible for staff health and safety. Rather they and other dedicated OSH staff assist management to fulfil its responsibility and duty of care concerning staff health and safety.

18. Risk management: This is a process where hazards in the workplace are identified and analysed in terms of the risk they pose and risk elimination or mitigation strategies are developed and implemented. Effective emergency response is an important element of risk management to reduce the impact work-related injuries, ill health, diseases and accidents.

19. OSH oversight body: Effective implementation of an organizations' OSH policy is best achieved through the appointment of a representative group of staff with a clear mandate and documented responsibilities in the form of an OSH committee. This committee should comprise, at the minimum, of staff representatives; representatives of the OSH medical and counselling services; representative from human resources; representatives from facilities and services management and; security services. Senior management commitment to OSH would be reflected through this committee being supervised by the Deputy CEO or his/her representative.

20. Training: A successful OSH programme is predicated on managers and employees, in particular those members of the OSH committee, having received training (and on a continuous basis) in order to understand their roles/responsibilities and expected actions, thereby achieving OSH goals.

21. All staff must be made aware of potential risks in the work environment and what measures have been adopted to minimize such risks. More importantly, they must be familiar with the OSH services that are available to them and what they do and do not provide. The components expected outcomes of such services are listed in Table 1 below. The extent to which such OSH services are provided is relative to each organization's risk profile.

Table 1

Representative Components and Outputs of an Organizational Safety and Health Programme[6]

Leadership/management:

- Organizational commitment;
- Innovation and change management;
- Health information systems;
- Program evaluation and quality improvement;
- Privacy, medical confidentiality and health records management systems;
- Systematic research, statistics and epidemiology.

Healthy workers:

- Health evaluation of workers (pre-assignment/pre-placement, medical monitoring, post illness or injury, fitness-for-duty evaluation and independent medical examinations);
- Occupational injury and illness management;
- Non-occupational injury and illness management (depending on local healthcare infrastructure);
- Travellers health and infection control;
- Mental and behavioural health/misuse of substances;
- Medical screening and preventive services.

Health environment:

- Workplace health hazard evaluations, inspection and abatement;
- Education regarding environmental hazards;
- Personal Protective Equipment (when exposure cannot be avoided);
- Toxicology assessments;
- Environmental protection programs;
- Emergency preparedness, business continuity planning and disruption prevention;
- Healthy organization (Health promotion programs);
- Health benefits management;
- Integrated health and productivity management.

OSH Implementation

22. While a few organizations have adopted an OSH policy (see Figure 1 below), the Inspector wishes to cite the Organization for the Prohibition of Chemical Weapons (OPCW) as the only organization that has implemented the OSH core elements stated above.[7] The ILO OSH announcement on the other hand does not make it clear that the Director-General takes personal responsibility, rather it is vested in the office, and nor does he/she specifically allocate resources

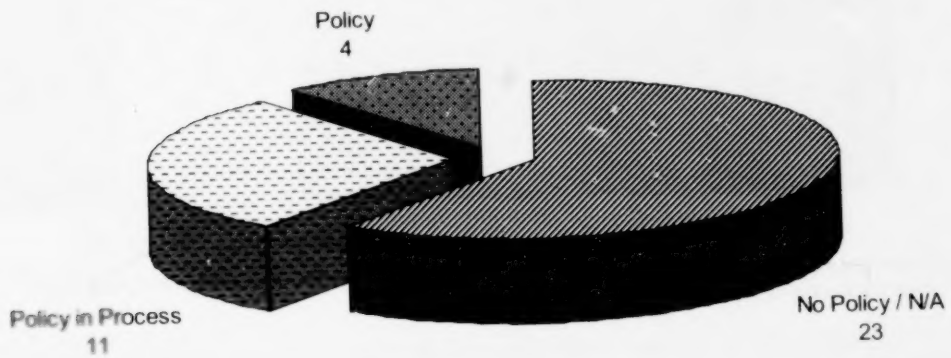
[6] Annex 1, "Occupational Health and Safety Policy in the UN System – Submission of the UN Medical Directors Working Group", CEB/2010/HLCM/11, 11 February 2010.

[7] OPCW Health and Safety Policy and OPCW Health and Safety Regulations, C-1/Dec 8, dated 14 May 1997.

for OSH, instead, "within the provisions of the programme and budget."[8] The World Health Organization (WHO) has just recently adopted an OSH policy, which in the Inspector's view incorporates key aspects of the core elements, but whereas the Director-General does not specifically assume responsibility, it is staff with managerial and supervisory responsibilities that do so.[9]

23. Being that as it may, the Inspector notes that many organizations are in the process of adopting their respective OSH policies, by designating focal points to drive this process, and in that respect some have already restructured their medical services to provide occupational health services for their staff at headquarters, and for some, in the field. Thus there is precedence and best practice for other organizations to follow.

Figure 1
Number of Organizations with OSH Policy Statement
(as of June 2010)



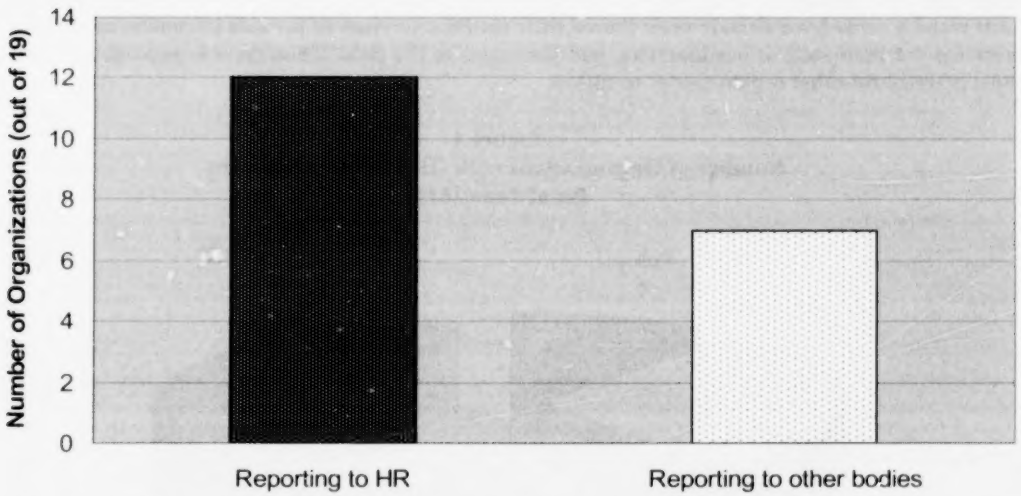
Note: Policy: IMO, OPCW, WHO, World Bank.
Policy in process: ESCWA, FAO, ILO, IOM, UNESCO, UNHCR, UNHQ (incl. UNDP, UNFPA, UNICEF), UNWTO.
No Policy: ECA, ECLAC, ESCAP, ICAO, ICTR, UNOG (incl. ITU, WIPO, WMO, ECE, UNCTAD, ITC), UNON (incl. UNEP, UN-HABITAT), UNOV (incl. IAEA, UNIDO, UNODC, CTBTO), UNRWA, UPU, WFP.

24. One key feature of OSH, and in particular that of OSH medical services, is that such services should remain independent from other administrative/organizational units and report either directly to the CEO or his/her appointed representative. This implies that OSH medical services, while working in close collaboration with human resources, must not report to them directly. This is the case already in some organization (see Figure 2 for the breakdown) where the medical services report to the Head of Administration/Executive Office. From a historical perspective it must be noted that the United Nations Medical Service in New York was under the Executive Office of the Secretary-General (see SGB 97/Rev.1 (1 January 1955) and 97/Amend.2 (6 October 1955) which designated the Health service as an "independent service reporting to the Secretary-

[8] ILO, Director-General's announcement, IODS number 48 (version 1), 11.11.2008.
[9] WHO OSH policy, para 8.

General through his Executive Office", until it was transferred to the Office of Human Resources Management in 1959, **to meet a temporary situation**, where it remains today.[10]

Figure 2
Reporting Chains of Medical Service in the Organization (at headquarters)
(as of June 2010)



Note: Reporting to HR: ESCAP, ESCWA, ILO, UNHQ, UNESCO, UNHCR, UNOG, UNON, UNOV, WFP, WHO, World Bank.
Reporting to other bodies: ECA, ECLAC, FAO, ICAO, ICTR, IOM, OPCW.

25. A successful OSH policy would also lead to cost-efficiencies. For example the majority of OPCW Health and Safety Branch medical expenses are for external referrals for medical examinations, pathology (blood) testing or radiology. Each of these activities is being progressively implemented, subject to an "evidence based" review. Well-established statistical proofs are used as the benchmark for either adding to, removing or changing aspects of each activity. To date, this has led to a 26% reduction in pathology costs, and a 90% reduction in radiology costs. In 2011 revised clinical examination guidelines will be put in place which is expected to result in a 30% decrease in overall pre-employment medical costs.[11] As well as monetary savings, this approach also saves significant staff time. This time is then directed towards newer strategies which have been demonstrated to yield positive results, such as active case management and enhanced early return-to-work programmes. This generates indirect savings such as reduced sick leave and disability rates, which in turn give significant benefits in the longer term, both as financial savings and removing or changing aspects of each activity.

26. The implementation of the recommendations below will enhance efficiency.

[10] Internal Memorandum to Mr. Joseph E. Connor, Under-Secretary-General, Department of Administration and Management from Ingrid Laux, Director, Medical and Employment Assistance Division, Office of Human Resources Management, 4 March 1996.

[11] Source: OPCW Health and Safety Branch.

Recommendation 1

Executive Heads of United Nations system organizations should appoint focal points in their respective organizations for developing the necessary Occupational Safety and Health policies and procedures and should present them, without delay, to their respective legislative bodies for adoption.

Recommendation 2

The legislative bodies of United Nations system organizations should, while taking account of emerging modifications to the Minimum Operating Safety and Security Standards, adopt appropriate standards for Occupational Safety and Health issues.

III. MEDICAL SERVICES IN THE UNITED NATIONS SYSTEM

27. The Director of the United Nations Medical Services Division (MSD) coordinates the system-wide implementation of United Nations medical standards and health policies, addresses health care issues arising from all duty stations, and ensures staff access to benefit programmes. He/she is accountable to the Assistant Secretary-General for Human Resources Management, and also acts as medical adviser on matters pertaining to the Advisory Board on Compensation Claims and is the designated medical consultant for the United Nations Joint Staff Pension Fund.[12]

28. Some of the core functions of MSD include:[13]

- To provide for the physical and mental health of staff worldwide and advise administration on staff benefits;
- To formulate and review United Nations medical standards, policies and guidelines, and ensure coordination and monitoring of system-wide implementation;
- To establish, update and coordinate United Nations system health advisories, including travel precautions, pre- and post travel examinations, consultations, vaccinations, health education materials and travel kits;
- To promote a healthy, safe and compassionate work environment through health policies and guidelines, health promotion programmes, comprehensive medical emergency preparedness plans, and coordinate system-wide implementation of medical policies for HIV/AIDS;
- To provide medical clearances for recruitment, reassignment and mission deployment of staff worldwide, military observers and civilian police monitors;
- To evaluate and certify sick leave for staff worldwide;
- To determine the health rating of all duty stations reviewed by the International Civil Service Commission;
- To provide psychological assistance in the context of mission assignments, substance abuse and emergency preparedness;
- To provide courtesy medical services to the staff of all permanent missions and observer missions to the United Nations and to visitors and contractors.

For New York-based staff of the United Nations system, including

- Medical examinations and consultations;
- Travel health clinic;
- "Walk-in" Clinic;
- Emergency and first-aid care;
- Referring to outside specialists or hospitals;
- Planning, organizing and implementing on-site health improvement programmes.

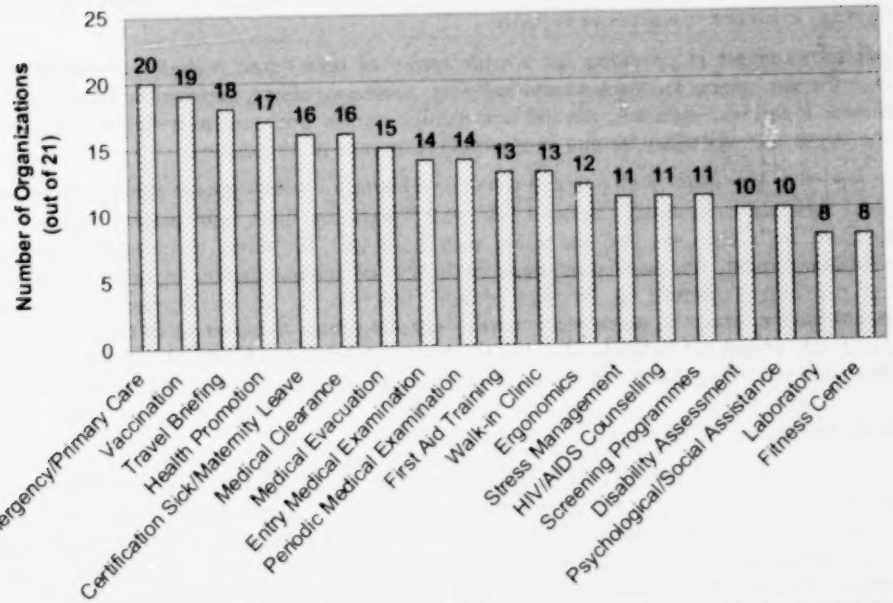
While the above describes the services provided by MSD, Figure 3 below indicates the medical/occupational health services that are provided by organizations at their respective headquarter locations.[14]

[12] ST/SGB/2004/8, Sections 7.1, 7.2 and 7.3.

[13] Ibid., Section 7.5.

[14] For detailed list of services provided at individual duty stations, see Annex I.

Figure 3
Major Medical Services and Programmes Provided at headquarter duty stations[1] (as of June 2010)



[1] UNHQ includes UNDP, UNICEF, UNFPA; UNOG includes ITU, WMO, WIPO, ECE, UNCTAD, ITC; UNOV includes IAEA, UNIDO, UNODC, CTBTO; UNON includes UNEP, UN-HABITAT.

29. Some duty stations have established in-house laboratories as they have determined that their presence onsite lowers costs (when compared with external providers) and is convenient for staff. Staff convenience and well-being were also reasons for establishing fitness centres which is indicative of management initiative and support. The Inspector wishes to highlight certain additional services that are provided at some headquarter duty stations, at little or no-cost to the organization, which may be replicated at other locations. These services are indicative of an organization's desire to provide a convenient means to improve general staff well-being. For example, the Food and Agricultural Organization (FAO) houses a private medical clinic in the premises, where apart from a general practitioner, the services of a physiotherapist are available. In Vienna, staff can schedule appointments with a private gynaecologist who has a weekly clinic in the Vienna International Centre (VIC). The VIC also houses a pharmacy, permitting staff to obtain their prescriptions without leaving the building. Some organizations also provide self-measurement blood pressure machines. Finally, the World Bank has a dedicated web site for health promotion and organizes regular information sessions on various health-related topics.[15]

30. Most organizations surveyed also offer assistance to their staff to deal with their work-related or personal problems that may adversely affect their work performance, health and general well-being. Such assistance is usually provided "in-house", either through staff welfare officers, staff counsellors, stress counsellors, ombudsmen, ethics officers and others addressing staff relations, or a combination of the above. It also may be outsourced to external providers, as

[15] For further information on measures adopted by United Nations system organizations concerning work-life balance, see forthcoming JIU report on "Inter-agency Staff Mobility and Work/Life Balance in the Organizations of the United Nations System".

is the case of the International Civil Aviation Organization (ICAO). To this end, the roles/descriptions of the service providers should be clearly delineated to avoid confusion/misunderstandings. The reporting lines of such providers are also important; in some organizations, the counsellors report to the medical service (UNHQ, WHO, FAO) and in others (the majority) to human resources or security.

31. Assistance/support is provided for a wide range of issues and include (non-exhaustive): conflict in the workplace; harassment and bullying; substance abuse; depression; burnout; work-life balance; loneliness/isolation; marital and family issues; pre- and post deployment issues; traumatic stress and secondary trauma and; human resources-related issues.

32. The reporting line issue is also linked with confidentiality. While those counsellors reporting to medical services have clearly defined "firewalls" between them, and patient files are kept separate from both services, and the same may hold true for those associated with human resources/management, the paramount concern is that of independence. In other words, staff members providing counselling services should function in an environment where their professional independence is guaranteed, thereby enabling them to better serve their client base. To this end, **the Inspector believes that these service providers should be neither reporting to medical, human resources nor security, but to the head of the OSH unit** (see Chapter II).

A. Medical Directors – Post Levels

33. While the position of Director of MSD is graded at the D-2 level, those of other medical directors are not at a similar level (see Table 2 below). The Inspector believes that posts of United Nations system healthcare staff should be consistently graded system-wide to accurately reflect the responsibilities that are shouldered on a daily basis both in the field and at headquarters. In fact, some medical chiefs had expressed their dissatisfaction regarding the discrepancies of post levels between duty stations with similar levels of responsibility, as some of them are not only in charge of their own organization, but of others as well.

Table 2
Grades of Medical Chiefs (headquarters)
(as of June 2010)

Organization	Grade
UNHQ (incl. UNDP, UNICEF, UNFPA)	**D2**
FAO	D1
UNHCR	**D1**
WHO	D1
UNOV (incl. IAEA, UNIDO, UNODC, CTBTO)	**D1**
UNOG (incl. ITU, WMO, WIPO, ECE, UNCTAD, ITC)	P5
UNON (incl. UNEP, UN-HABITAT)	**P5**
ILO	P5
UNESCO	**P5**
UNRWA	P5
WFP (under FAO)	**P5**
ECA	P5
ECLAC	**P4**
ESCAP	P4
ESCWA	**P4**
ICTR	P4
OPCW	**P5**
IOM	P4
ICAO[5]	**N/A**
World Bank[6]	N/A

[5] Medical Chief is a consultant.

[6] World Bank has a different grading system.

34. For example, the medical chief positions at UNOG and UNON should be upgraded to that of Director, as they have not only inherent decision-making powers and powers and are functionally independent from MSD, but are also responsible for services provided to many international organizations (headquarters) in Geneva/Nairobi on a cost-sharing basis. The Inspector is also of the view that the positions of the medical chiefs in the regional commissions (ESCAP, ESCWA and ECLAC) should be reclassified to a senior managerial level and those positions that are currently financed through extra-budgetary funds, to be converted to regular budget posts pending reclassification.

B. Staff Member Medical Records

35. With an emphasis today placed on staff mobility and increased field presence within the United Nations system, and from an administrative point of view, staff member medical records should be easily accessible/transferable within duty stations. Apart from medical records being available electronically, their storage in this medium will also meet current business continuity and disaster recovery requirements.[16] Table 3 below indicates the number of organizations that have implemented this practice.

Table 3
Availability of Staff Member Medical Records in electronic format (as of June 2010)

	Organizations	TOTAL
Yes	ECLAC, ESCAP, FAO, UNHQ (incl. UNDP, UNFPA, UNICEF), UNOG (incl. ITU, WIPO, WMO, ECE, UNCTAD, ITC), WFP, WHO, World Bank	17
No	ECA, ESCWA, ICAO, ICTR, ILO, IMO, IOM, OPCW, UNESCO, UNHCR, UNON (incl. UNEP UN-HABITAT), UNOV (incl. IAEA, UNIDO UNODC, CTBTO), UNRWA, UNWTO, UPU	21

36. The Inspector notes that organizations have adopted different programs for electronic filing of medical records; from EarthMed at United Nations headquarters, to CHIMED/Préventiel at WHO to Jasmine Web (UNOG). While there would be a natural tendency to seek the adoption of one program for all, nevertheless the organizational choice of an electronic records platform should be respected. However, such platforms should to the extent possible enable system-wide compatibility. They should also be able to interface with Enterprise Resource Planning (ERP) systems while ensuring the protection of confidential medical information.

37. The implementation of the recommendation below will facilitate the dissemination of best practices.

[16] A/RES/63/269, 7 May 2009.

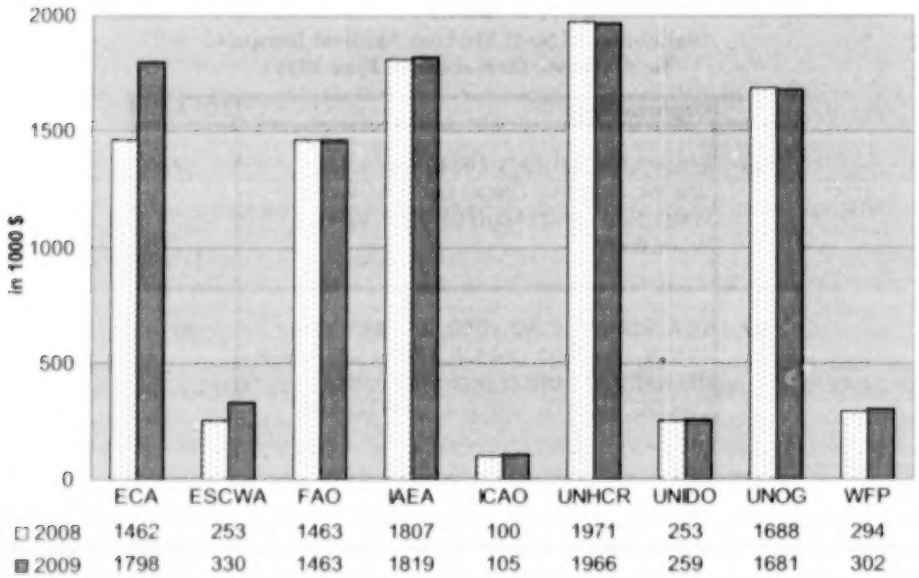
Recommendation 3

Executive Heads of United Nations system organizations should, if not already in place, implement systems permitting the electronic capture/archiving of staff member patient records.

C. Financing of Medical Services

38. At headquarter duty stations, the Inspector notes from the responses to his questionnaire that resources, in general, are sufficient for providing adequate medical services. All organizations either maintained or increased their budgetary resources (regular or extra-budgetary, or insurance participation). Figure 4 below lists some organizations and the resources allocated for medical services.

Figure 4
Budget for Medical Services at select organizations (HQ) 2008-2009



Source: Organizations' reponse to Inspector's questionnaire

39. Nevertheless, some organizations, such as ECA, ECLAC, IAEA, ILO MSD, UNICEF, UNHCR and WHO, stated, in their responses to the Inspector's questionnaire, that there were insufficient resources to, for example:

- Hire additional medical service staff, including staff counsellors, to improve service delivery;
- Deliver training to medical service personnel;
- Support health promotion programmes;
- Introduce a database and perform statistical analysis of work being done;
- Respond to emergency situations in the context of a national pandemic;
- Establish a satellite clinic in the Somali regions;

- Carry out mobile clinics from Addis Ababa to other regions.

40. It is not possible to include the quantum of financing for medical services provided by dispensaries as UNDP did not respond to the Inspectors' questionnaire and MSD does not have access to such information. Nevertheless, each dispensary is financed on a cost-sharing basis and thus there is collective responsibility placed on all organizations whose staff use the facilities. The prevalent use of United Nations volunteers (see figures 6 and 7) is perhaps indicative of the desire to minimize costs for the provision of medical/OSH services.

D. Medical Services in the Field

41. United Nations staff are increasingly deployed to field duty stations, including to many areas with suboptimal medical and health-care infrastructure. These deployments come with an increased risk to health and safety, as evidenced by recent attacks on United Nations premises (in Baghdad, Algiers and Afghanistan), and exposure to natural disaster (such as Haiti).[17]

42. The UNMDWG at its 2010 annual meeting in Geneva, specifically expressed their concerns to the Inspector, that while in general, medical services at headquarters are sufficient, the same cannot be said for those in the field. "It is a fact that Headquarters staff benefit to access to world class local medical services, while field staff are often at risk in an environment where healthcare infrastructure, including that of the United Nations, is inadequate."[18] Similar views were expressed in response to the Inspector's questionnaire to participating organizations and staff associations as well as in meetings with concerned stakeholders.

43. Excluding facilities of troop-contributing countries in peacekeeping missions, the United Nations currently operates 121 health-care facilities in field locations (United Nations dispensaries and civilian clinics in peacekeeping operations). Some 166 doctors and 197 nurses, and a similar number of support staff, are currently employed by the United Nations to work in these field facilities.[19] A dispensary is expected to provide primary clinical care and occupational health services (see Annex II for a list of services) to a sufficient number (at least 200) of internationally and nationally recruited personnel of the United Nations system and their recognized dependants where the locally available medical facilities are found to be inadequate.[20] However, if the health conditions in a country constitute an emergency, the United Nations Medical Director can, after consultation with the other Medical Directors in the United Nations system, recommend the establishment of a Dispensary.[21] This recommendation is submitted to the United Nations Resident Coordinator/Resident Representative who then forwards the proposal to the United Nations agencies concerned to obtain their agreement.

44. While MSD provides technical support to these facilities, by way of supervision of the medical staff, their administration/management is usually given to the country teams, and individual overall accountability to either the Resident Coordinator or Special Representative of the Secretary-General. Hence, as a matter of urgency, the management and accountability framework for supporting United Nations clinics and dispensaries in the field should be clarified and promulgated in a defined Terms of Reference (TOR) taking into account of the inter-agency common services they are required to deliver. **The Inspector was informed that to date, such clinics are established/managed on a draft UNDP TOR.**[22] Challenges faced in the resourcing

[17] A/65/305, 2 September 2010, para 140.

[18] Consolidated response to JIU presentation at October 2010 UNMDWG Annual Meeting.

[19] A/65/305, 2 September 2010, para 141.

[20] "UN Dispensaries DRAFT" UNDP Office of Human Resources Bureau of Management, 2009.

[21] Ibid., para 11 (b).

[22] Referred to "Guideline for Provision of Field Health Services."

of United Nations field medical facilities, particularly United Nations dispensaries, should be addressed, considering the services they are expected to deliver in difficult and often isolated circumstances. These should be taken into account when finalizing the above-mentioned TOR.

45. The Inspector was informed by WHO that when the management of dispensaries was decentralized to the country level (under the Resident Representative and/or Country Team) and on an inter-agency cost share basis, it became unmanageable and no one was really responsible or held accountable and that there were disagreements on the cost share by various agencies. When there was centralized management by UNDP at UNHQ, the procurement for dispensaries was done globally by WHO. With decentralization, WHO did not regularly receive reimbursements for advanced orders and this was one of the reasons for their terminating this practice.[23]

46. Similar concerns have been addressed by the Inter-Agency Security Management Network (IASMN) as they noted with concern the limited resources in the United Nations system to manage, support and monitor field medical services. It therefore supported and encouraged the ongoing efforts of the Medical Directors Working Group to establish an infrastructure capable of ensuring adequate health care including emergency medical services for the United Nations system staff worldwide.[24] They further recommended that United Nations Medical Dispensaries be properly staffed and equipped to assist United Nations staff in the event of mass casualty incidents by supplementing local response capabilities to the extent practicable.[25] The UNMDWG had also noted that the future strategic direction of the United Nations system includes greater emphasis on field presence and mobility of staff. This has critical implications for the health standards applied during the selection of staff, and the provision of supportive health care services for staff deployed in areas with inadequate medical infrastructures.[26] The Inspector strongly supports the above-mentioned positions.

47. The implementation of the recommendation below will enhance accountability of all stakeholders.

Recommendation 4

The United Nations Development Programme Administrator, in consultation with the United Nations Medical Services Division and UNMDWG, should finalize and adopt the Terms of Reference for the administration of United Nations Clinics and Dispensaries, thereby ensuring consistent and transparent management practices to meet the medical requirements of concerned United Nations system staff.

E. Field Medical Service Providers

48. Figure 5 below shows the linkages between the field medical service providers. While MSD could be considered as the nucleus and linked to all, with the exception of the CISMU/DPKO Counsellors, some providers do not interact with each other. While the report will describe the role/functions of each service provider, it is clear from the graphic and further elaborated in the text, that clear accountability/reporting lines are missing and thus the difficulty in obtaining system-wide coherence on the subject issue at hand. For example, MSS provides the necessary

[23] WHO response to Inspector's questionnaire.

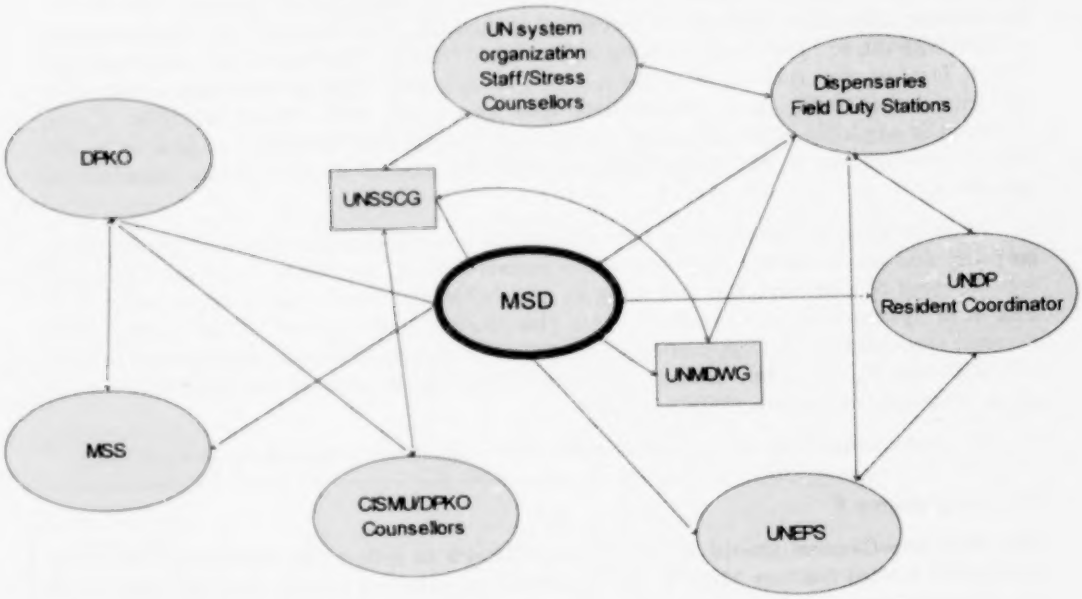
[24] Report of the Inter-Agency Security Management Network (Lyon, 28-30 July 2008), CEB/2008/HLCM/13, para 50.

[25] CEB/2008/HLCM/13, para 25.

[26] CEB/2009/HLCM/32, para 9.

logistical support for the DPKO medical facilities and yet they are not called upon to provide similar services to dispensaries, where synergies could be maximized.

Figure 5
Field Medical Service Providers - Linkages



United Nations Medical Services Division

49. MSD is tasked with the managing, supporting and monitoring of a globally distributed healthcare service which currently crosses Departmental and Organizational boundaries. It ensures staff worldwide access to health services by:[27]

- Advising on and assisting with medical evacuation and repatriation requests by staff and their recognized dependants, military observers, civilian police monitors and United Nations peacekeeping troops;
- Making periodic on-site assessments of local health facilities and living conditions at field duty stations and advising staff and administration accordingly;
- Advising on and assisting in establishing new United Nations field medical facilities, when and where necessary;
- Providing technical support to all United Nations medical facilities;
- Appointing and reviewing United Nations examining physicians in all duty stations;
- Evaluating and providing technical clearance for all candidates applying for medically related United Nations posts, including United Nations volunteers, nurses and medical technicians.

[27] ST/SGB//2004/8.

50. However, MSD faces challenges in undertaking the above roles. Indeed, the Secretary-General has noted that the capacity of the United Nations to manage, support and monitor a globally distributed health-care workforce is minimal.[28] Apart from resource constraints, issues concerning lines of authority, responsibility and accountability need to be addressed. Specifically, the majority of the United Nations healthcare staff (doctors, nurses and paramedical staff) that MSD "oversees" actually work for different organizations, or in different departments. For example, physicians deployed in peacekeeping missions have contracts with the Department of Field Support, and physicians working in the United Nations Dispensaries have contracts with UNDP. The Inspector is of the view that it is very unlikely that MSD, as supervisor, can exercise authority, responsibility, and accountability over supervisees when he/she has little, if any, influence in employment decisions, has no input on budgets and work plans of field units, and has no involvement in the performance management process of the various organizations concerned.

51. While medical services in most duty stations have relatively clear internal reporting lines, authority and accountability, the Inspector is recommending, in Chapter V of the report, the establishment of a network that will bring all stakeholders involved under a single structure to deal with system-wide accountability. This also implies modifications to the current MSD mandate stipulated in the Organization of the Office of Human Resources Management bulletin (ST/SGB/2004/8), taking into account their role in the proposed network and the emphasis to be given to the implementation of OSH policies.

52. The implementation of the recommendation below will enhance the effectiveness of MSD.

Recommendation 5

The Secretary-General should modify ST/SGB/2004/8 to reflect the revised mandate and role of the United Nations Medical Service Division, ensuring effective implementation of the Occupational Safety and Health policies and the United Nations global healthcare system.

53. Prior to 2007, the only direct contact that MSD staff had with field physicians was limited to the 6-8 budgeted assessment visits conducted by MSD per year. Considering the large number of facilities that actually fall under MSD's umbrella of professional supervision, each facility could only be visited approximately once every 8 years, falling far short of any reasonable managerial monitoring requirement. When the current Medical Director took office in 2007, and noting the above, he instituted the practice of an annual meeting for field physicians, one conducted for the United Nations Dispensary physicians, and one for the physicians from Peacekeeping missions. Limited headquarter funding covered only the attendance of MSD staff to these meetings, and Country Teams and Missions were requested to cover the costs of their physician's attendance. The intention of these meetings was to provide the opportunity for direct interaction between Headquarters and field medical staff, explanation and coordination of United Nations medical policies and procedures, and professional networking and communication for doctors sharing similar difficulties and circumstances. In addition, the meetings were used for training and development purposes. For example, and following the concerns expressed by the Medical Directors regarding medical emergency preparedness in their February 2009 paper to the HLCM,[29] MSD arranged internationally certified training in Pre-Hospital Trauma and Life Support (PHTLS) at both of the field physician meetings in 2009. This was followed in the 2010

[28] A/65/305, 2 September 2010, para 141.

[29] CEB/2009/HLCM/17, 18 February 2009.

meetings by a two day tabletop simulation training covering the Communications and Organizational Management processes for responding to crises and Mass Casualty incidents. During the planned 2011 meetings, field physicians will be trained in how to adapt and apply planning templates for emergency preparedness at their own duty stations.

54. In order to further develop the contact and communication for all United Nations healthcare staff (field and headquarter-based) MSD should identify additional resources required to achieve this purpose and submit a proposal to the Secretary-General through the appropriate channels, for onward transmission to the General Assembly for consideration.

United Nations Examining Physicians

55. MSD is responsible for appointing United Nations Examining Physicians (UNEPS), based on recommendations made by Resident Coordinators and WHO representatives, and for issuing an updated list on an annual basis. Their services are available for all United Nations system organizations. UNEPS are not given any formal contracts and their fees for services provided are expected to be reasonable and customary.

56. The main functions of UNEPS include the performance of: pre-employment medical examinations; periodic medical examinations; Exit medical examinations (if required); assisting with medical evacuations, i.e. if a staff member or eligible dependant needs to be medically evacuated, the United Nations Examining Physician is required to make his/her recommendation to the Head of the Fund/Program/Agency the staff member belongs to and; assist with sick leave and other medical/occupational health issues.

57. While there are over 600 UNEPS in the field,[30] the Inspector notes that there is no systematic monitoring and evaluation of the services they provide and the list is updated sporadically. MSD does assess those UNEPS in the areas where they undertake missions (between 6-8 per year) to field locations, but this is a very small percentage of the full group. Some organizations have complained about the reliability of the listing, as some UNEPS have either retired or, in some cases, passed away, and thus rely on other health care providers for the required services.

58. The implementation of the recommendation below will ensure control and compliance with the responsibilities assigned to MSD.

Recommendation 6

The United Nations Medical Services Division should develop an effective monitoring and evaluation tool for assessing the services provided by United Nations Examining Physicians as well as updating the global list on an annual basis.

Department of Peacekeeping Operations

59. The purpose for United Nations medical support for peacekeeping operations is to "secure the health and well-being of members of the United Nations peacekeeping operations through planning, coordination, execution, monitoring and professional supervision of excellent medical care in the field."[31] The medical support extended to DPKO personnel must meet standards that

[30] Source: MSD response to Inspector's questionnaire.

[31] Chapter 1.01, Medical Support Manual for United Nations Peacekeeping Operations (2nd edition), DPKO/OPS/MSU, 1999.

are acceptable to all participating nations and the standard of care must be comparable to prevailing peacetime medical care. Such support, therefore, must maintain a high state of readiness and availability, providing timely, responsive and continuous care to any patient or casualty within the medical system.[52]

60. DPKO has adopted a four-level medical support organization, with the classification determined by its treatment capability and capacity. (See Annex III for description). The allocation of medical resources is intrinsically linked with the peacekeeping mandate, type of peacekeeping operation, existing medical infrastructure, geographical factors and assessed medical threats. Prior to the establishment of a peacekeeping mission, a technical survey is conducted in the potential mission area in order to determine the main medical threats as well as the medical facilities/resources required to support peacekeepers and international staff in such an operation.

Peacekeeping mandate: Official United Nations policy is that there is no obligation to provide or take responsibility for medical services to the local population, though this is sometimes rendered according to the dictates of international humanitarian law and the ethical code of the medical profession.[53]

Type of peacekeeping operation: While missions involving only military observers/ civilian police often do not require the deployment of a medical unit, those that are of a high-risk nature, such as peace enforcement and demining do.[54]

Existing medical and civil infrastructure: Where local hospitals and clinics within the Mission area do not meet acceptable United Nations standards, or where these are not readily accessible, there is a requirement to deploy a higher level of medical support within the Mission, regardless of its troop strength or deployment.[55]

Geographical factors: Terrain, accessibility by land and air, physical distance, climate and other geographical factors influence the level of medical support required and deployment within the Mission area. Where there are good land communications and/or adequate air evacuation assets, local medical facilities and those in a nearby country may be utilized, instead of deploying United Nations medical units. Where access is poor, medical units of varying sizes and capabilities may be deployed.[56]

Medical Threat Assessment: Deployed medical units should meet the daily health care needs of United Nations personnel in the field. As such, apart from treating minor ailments (primary health care) and endemic infectious diseases, they may be required to manage severe trauma and mass casualty situations. The latter may arise as a result of direct acts of hostility and where land mines are involved, particularly if civilians are treated under a humanitarian mandate. Thus deployments of field surgical units, radiology facilities, laboratories and blood banks may be warranted. It is also important to have dental facilities.

---

[52] Ibid., Chapter 1.02.

[53] Standard 10.40, Medical Support to Demining Operations, pp. 110-11, "A Guide to International Mine Action Standards" Edition 2010, Geneva Centre for Humanitarian Demining.

[54] DPKO: International Standards for Humanitarian Mine Clearance Operations, pp. 49-51. New York, United Nations, 1998.

[55] Chapter 4.02c, Medical Support Manual for United Nations Peacekeeping Operations (2nd edition), DPKO/OPS/MSU, 1999.

[56] Ibid., Chapter 4.02d.

Medical Services Support – Department of Field Services

61. The Medical Support Section (MSS), Specialist Support Section (SSS) under the Logistics Support Division (LSD) of the Department of Field Support (DFS) is the executive arm of the United Nations for the planning, coordinating and monitoring of medical logistics support to field missions. It provides technical advice on all health-related issues to DFS/DPKO where it is integrated within their logistics systems. MSS also operates in close collaboration with MSD. Its core functions can be grouped into six areas: Advisory; Coordination; Medical Support Planning for Field Missions; Medical Logistics; Procurement; and Training. See Annex IV for a specific breakdown of activities.

62. DPKO issued the first edition of the Medical Support Manual for United Nations Peacekeeping Operations in 1995 and revised in 1999 to meet the requirements for a standard reference document for planning, coordinating and executing medical support as well as a tool for training peacekeepers and medical personnel on medical aspects of United Nations peacekeeping operations.[37]The current edition is being revised and will incorporate lessons learned from recent peacekeeping operations and focus on the improvement of the quality of medical services provided to peacekeepers and on achieving greater efficiency in medical evacuation within and out of a mission area.[38]

Critical Incident Stress Management Unit

63. The United Nations Department of Safety and Security Critical Incident Stress Management Unit (UNDSS CISMU) was established as a distinct unit within UNDSS in 2000 as a result of a General Assembly mandate which expressly sought to address the needs of the increasing number of United Nations staff exposed to traumatic events while in service to the organization.[39] From a historical perspective, with the creation of the Office of the United Nations Security Coordinator (UNSECCORD) in 1988, the counselling role emerged as security officers began to provide such services to staff working in hazardous environments and facing security threats and psychosocial risks. It soon became evident that there was a need to secure the services of professional counsellors to look after staff affected by critical incidents. In this respect, the deployment of counsellors enhanced security operations and in May 1994, the Administrative Committee on Coordination (ACC) concluded that "in view of the link between security incidents and critical-incident stress the United Nations Security Coordinator should serve as the focal point for developing strategy to manage stress ... there should be a two-tiered strategy for stress-management: preventive stress management and critical-incident stress management."[40]

64. Based on the mandate given, CISMU has two key roles: strategic and operational. For the former, it provides strategic guidance, design approaches and educational tools on critical incident stress prevention management to senior/line managers, organizations and security management teams in both headquarters and the field. For the latter, it monitors and responds to critical incidents system-wide and provides capacity building for staff on preventive stress management including preparedness to respond to psychosocial emergencies.

65. CISMU, apart from chairing the recruitment panels of the DPKO/DFS/DPA field staff counsellors, is responsible for their technical supervision and the system-wide coordination of

[37] Chapter 1.05, Medical Support Manual for United Nations Peacekeeping Operations (2nd edition), DPKO/OPS/MSU, 1999.

[38] A/64/643, para 42, p.27, 1 February 2010.

[39] A/RES/56/255.

[40] A/C.5/49/56, May 1994, p.2

their psychosocial and counselling activities. To this end, the Inspector notes the possible overlapping of mandates as MSD is also given the responsibility to "provide psychological assistance in the context of mission assignments, substance abuse and emergency preparedness."[41] While CISMU and DPKO Counsellors provide services for critical incidents in the field, there will be circumstances where they will be required to perform other counselling services. In fact, the issue has been raised in IASMN as to whether CISMU should remain in UNDSS or move to MSD or elsewhere within the Department of Management.[42] The Inspector is of the view that the proposed establishment of the United Nations Network on Occupational Safety and Health (UNNOSH), discussed in Chapter V of the report, and where CISMU should be a member, would facilitate inter-departmental coordination in this area.

United Nations Field Medical Services Staff

66. The Inspector would like to draw attention to the disparities in staff grading in the field. To this end, Figures 6 and 7 below indicate the staffing and grade levels of medical staff serving in peacekeeping missions and country offices. As is the case with the Medical Directors at headquarters, a similar harmonization for medical staff is required. This is of particular relevance to field medical staff, who are often isolated from collegial support and specialist referral networks and whose decisions can have life or death consequences. Dispensary and civilian clinical physicians have expressed dissatisfaction regarding the discrepancies of post level between duty stations with similar levels of responsibility, as well as with the overall lack of recognition of the high level of responsibility required.[43] In addition, there is no system of organized career progression, and marked job insecurity.[44] OIOS has also expressed similar concerns during their meeting with the Inspector as they felt that some dispensary doctors were given responsibilities that were not commensurate with their grades.

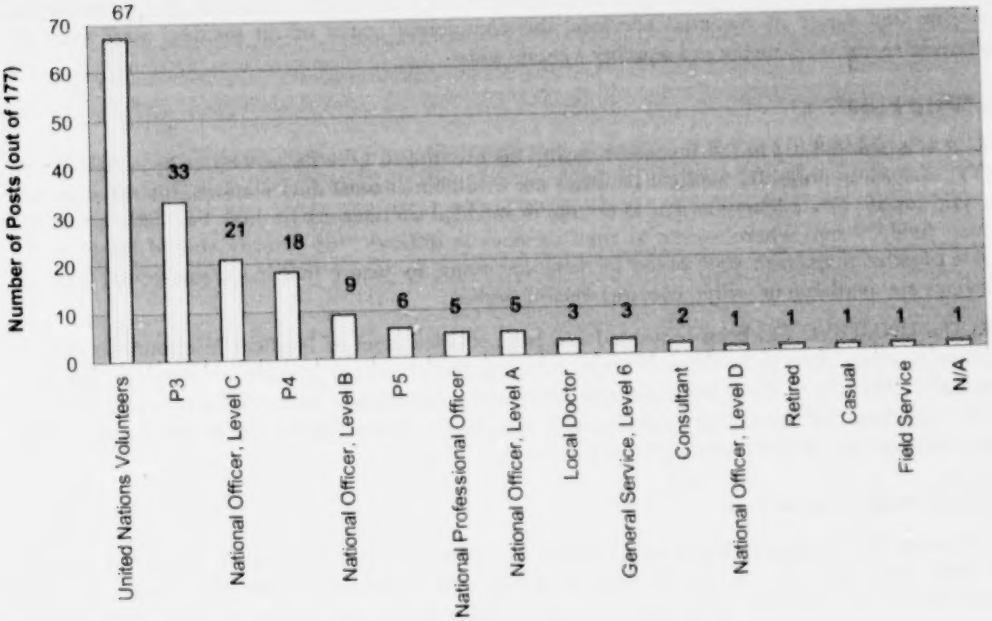
[41] ST/SGB/2004/8, Section 7.1.

[42] Minutes of IASMN Meeting, Nairobi, 1-5 February 2010, para. 72.

[43] UNMDWG, Statement on Field Health Care (Washington DC, March, 2008), Attachment 1, CEB/2009/HLCM/17, 18 February 2009.

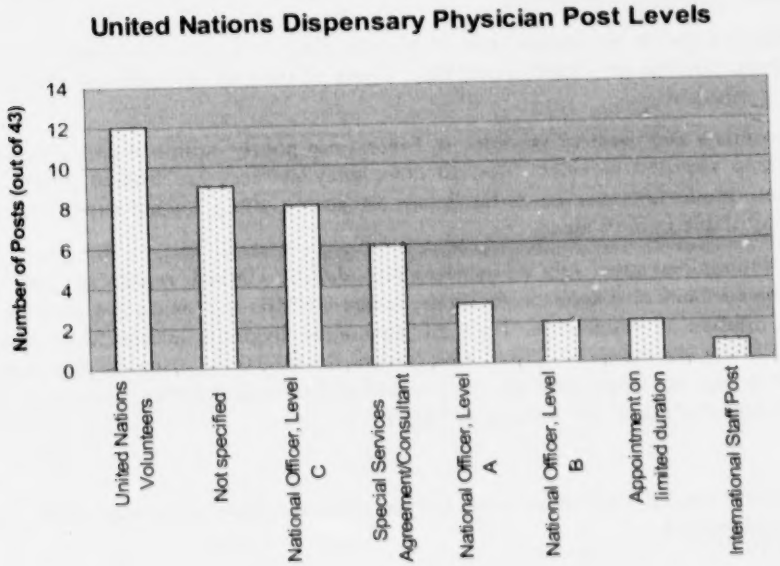
[44] Ibid.

Figure 6
Healthcare Staffing Levels in United Nations Peacekeeping Missions
(as of September 2010)



Source: MSD

Figure 7
United Nations Dispensary Physician Post Levels
(as of June 2010)



[1] As contracts are given by Resident Coordinator, the exact post level is not known by the Chief Medical Doctor.

67. The majority of the medical service positions in the field are held by United Nations volunteers. These staff, while being professionally competent and motivated and performing basically similar functions at different locations are under different contractual arrangements and in some cases with precarious lengths and conditions. For credibility purposes, and to ensure the stability and range of essential services, the contractual status of all medical staff must be reviewed to ensure fairness and equality system-wide.

F. "Deep Field"

68. It was pointed out to the Inspector during his mission to Liberia, as well as by UNHCR and WFP, that while normally medical facilities are available at most duty stations, the same cannot be said for all. Some locations are so remote or medical services are limited. For these areas, the "deep field,"[45] and where access to such services is difficult, top priority should be given by those organizations with staff based in these locations, to ensure that basic/emergency medical services are available or within easy/reasonable access.

69. The UNMDWG has been requested and has provided a set of Medical Minimum Operating Standards which have to be adapted for inclusion in the Minimum Operating Safety and Security Standards (MOSS).[46] Their inclusion into MOSS, and subsequent implementation, will result in additional costs for those organizations with staff in the "deep field". The Inspector notes that such costs are not only unavoidable but necessary.

G. Case Study Liberia

70. Current JIU budget restrictions prevented the Inspector from visiting an acceptable sample of field duty stations. To compensate, however, the Inspector sought the views of Staff Associations, in particular with those having a field presence. He wishes to thank in particular the headquarter Staff Associations of FAO, WFP and UNICEF for having obtained feedback from their respective field counterparts. The pervasive theme conveyed by them is that the headquarter staff are privileged for most services provided to them are not available to those serving in the field. The Inspector also obtained information on medical facilities in select field duty stations as a result of WHO and MSD sharing confidential evaluation reports prepared by them, for which gratitude is expressed.

71. The Inspector shares his impressions of his site visit to, and the challenges faced by, the United Nations Mission in Liberia (UNMIL). These challenges are perhaps similar in other peacekeeping missions.

72. Local hospitals and medical facilities in Liberia are poorly equipped and are incapable of providing many required services. Medical emergency services are limited, blood supply is unreliable and unsafe for transfusion, medicines are scarce, often beyond expiration dates, and generally unavailable in most areas.

73. United Nations personnel rely on services provided by UNMIL resources. There is still a lack of advanced medical diagnostic facilities; hence UNMIL still evacuates patients to Accra (Ghana) for routine investigations. Poor environmental hygiene, access to safe water and sanitation facilities are the most serious risk factors for infectious diseases. Peacekeepers and United Nations staff are being affected by food and water borne diseases. Malaria is one of the major health risks that personnel encountered there.

---

[45] A term originally used by UNHCR and which has now obtained widespread acceptance/usage within the United Nations system.

[46] CEB/2009/HLCM/17, 18 February 2009, para 3.

74. The United Nations Dispensary services all United Nations staff members and their dependents. Attendance increased from 1,963 in 2008 to 3,292 in 2009. This increase resulted in a huge depletion of consumables (drugs, supplies, vaccines) and the Dispensary has run out of many essential drugs that must be replenished urgently.

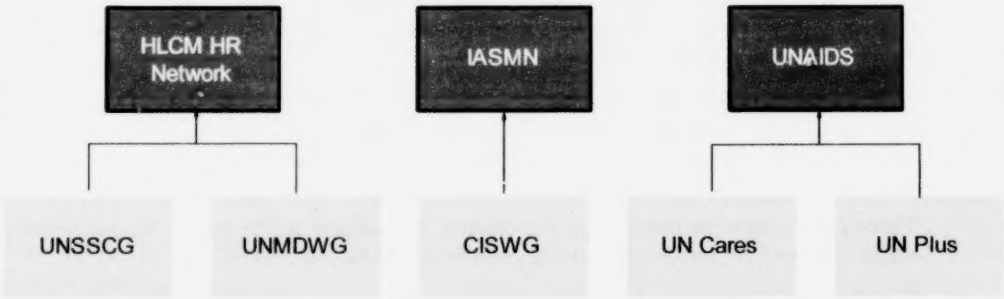
75. The following operational challenges were mentioned by the UNMIL medical service:

- Due to insufficient staffing of the Medical section, United Nations Level 1 clinics in some regions are in operation with a single doctor or a nurse;
- Unavailability of competent medical supplier locally to support the huge number of UNMIL medical facilities in case of urgent need;
- Unavailability of contracted (global) air medical evacuation facilities to transport critical patients to Level 4 hospital and beyond;
- Medical support provision in some sectors in Liberia depends on Troop Contributing countries (TCC) medical support. However, the specific TCC medical facilities in the region do not take this into consideration when sourcing drugs and other medical supplies;
- There are no training facilities in the country for medical professionals for continuous medical education; integrated training centres should be established;
- Certification of medical staff should be reviewed by the United Nations. As medical professionals are recruited worldwide, having doctors and nurses practice in a uniform manner is at times difficult.

IV. CURRENT SYSTEM-WIDE MEDICAL SERVICE COORDINATION/COOPERATION

In this chapter, the various system-wide/inter-agency bodies (and their reporting lines as shown in Figure 8) that coordinate/cooperate on Medical/OSH Services will be presented. Figure 8 is indicative of the absence of a system-wide "umbrella" coordinating body.

Figure 8
System-wide/inter-agency Medical/OSH bodies



A. United Nations Medical Directors Working Group (UNMDWG)

76. UNMDWG was formally established and recognised by the High-Level Committee on Management (HLCM) in March 2005, after being in existence since 1996.[47] It adopted a statement of purpose which established its mandate in broad terms. The group, composed of, but not limited to, the medical directors of the United Nations and the Specialized Agencies, also includes the medical directors of other intergovernmental development agencies.[48]

77. Its objectives are to optimize the health and well being of staff of the United Nations, the specialized agencies and intergovernmental organizations through the collaboration and coordination of their medical services.[49]

78. The group, which meets once a year and chaired by tradition by the United Nations Medical Director, promotes and shares medical, technical and professional knowledge and resources in the area of occupational health; promotes best practices and procedures of the medical services; initiates and harmonizes proactive occupational health policies throughout the United Nations common system and; presents recommendations and expert advice to the administrations of member organizations and to appropriate bodies of the common system.[50]

79. There are no specific costs/commitments required for group membership; members are expected to cover their own travel costs to attend meetings. The World Bank, from inception in 1996, and FAO thereafter, have provided secretariat services on a pro bono basis. The World Bank is hosting/updating the group's website.

---

[47] CEB/2005/3, para 76 (b), 23 May 2005.

[48] The UN Medical Directors Group – document submitted by FAO, CEB/2005/HLCM/R.12, 24 March 2005.

[49] Ibid., para 5.

[50] Ibid., para 6.

80. UNMDWG has recently submitted a series of papers to HLCM drawing attention to the Group's concerns regarding emergency medical management; the capacity of the United Nations to support, monitor and manage the globally distributed workforce of the United Nations healthcare staff and; the need for safety and health policy in the United Nations system.[51] These papers have been endorsed by the HLCM.[52]

81. The Group has also produced a plethora of position and policy guidance statements over the years, on topics such as screening and testing of HIV/AIDS; continuing professional development of medical staff; guidance for upgrade of travel class for medical reasons; medical confidentiality and; employment of disabled persons. In 2002-2003, they coordinated an inter-agency project to facilitate health education, prevention and care for HIV/AIDS for UN staff and families, whose final outcome contributed to the creation of UN Cares.[53]

B. United Nations Staff/Stress Counsellors Special Interest Group (UNSSCG)

82. The Group is comprised of mental health professionals and social workers in the positions of staff/stress counsellors in the United Nations system and related organizations.[54] Its mission is to promote the welfare, psychological and social well-being of the staff and the organizations.[55]

83. The first group meeting was organized by WFP in 2000, when they invited counterparts from other organizations to join and share their work experiences and visions about the future direction of staff counselling in the United Nations system. Formal recognition of the group as part of the Human Resources Network (HRN) by the CEB took place at the HRN meeting in February 2010.[56]

84. Like the UNMDWG, there are no costs/commitments for Group membership; and members are expected to cover their own costs to attend the annual meetings and participate in working group meetings. The Inspector encourages organizations to support the participation of their staff counsellors at these meetings, thereby ensuring adequate system-wide participation and fulfilling the group's mandate as endorsed by the HRN.

85. The Inspector welcomes the formal training sessions that have been organized for the membership by the group to coincide with their annual meetings. The identification and communication of professional and technical standards and providing opportunities for relevant continuing education should continue to be one of the cornerstone activities of the group. The Group had submitted a proposal to HRN on Confidentiality Guidelines for the United Nations Staff/Stress Counsellors which has been adopted[57] and is currently finalizing a proposal on Guidelines for Staff/Stress Counselling Services in the United Nations system.[58]

C. Critical Incident Stress Working Group (CISWG)

86. UNDSS, and its predecessor, the Office of the United Nations Security Coordinator (UNSECOORD), were mandated by the General Assembly to "ensure that all United Nations

---

51 CEB/2009/HLCM/17, 23 March 2009; CEB/2009/HLCM/32, 21 October 2009; CEB/2010/HLCM/11, 15 March 2010.

52 CEB/2009/3, 23 March 2009; CEB/2009/6, 21 October 2009; CEB/2010/3, 15 March 2010.

53 "Guideline for providing access to care and treatment for HIV/AIDS to UN system employees and their families", WHO publication, 2004.

54 "Staff/Stress Counsellors' Group – Mandate", Annex 2, CEB/2010/HLCM/HR/18, 28 March 2010.

55 Statement of Purpose, reviewed and finalized at the September 2003 annual meeting.

56 "Conclusions of the Meeting of the Human Resources Network", CEB/2010/HLCM/HR/18, 28 March 2010.

57 CEB/2010/HLCM/HR/35, 27 September 2010 - paras. 110-111.

58 UNSSCG response to Inspector's questionnaire, July 2010.

staff members receive adequate security training, including physical and psychological training prior to their deployment in the field and … through the implementation of a comprehensive security and stress and trauma management training, support and assistance programme for United Nations staff throughout the system, before, during and after missions."[59] Thus, as a step to ensure a coordinated and coherent response to critical incident stress management, IASMN endorsed the establishment of the CISWG in April 2005 as the governing and coordinating body to formulate policy and standards for submission to IASMN for decision.

87. CISWG members, nominated by their respective Security focal points, develop/promote policies to enhance the provision of Critical Incident Stress Prevention and Management in order to improve the psychosocial well-being of United Nations system staff and improve coordination between UNDSS staff/stress counsellors and security through IASMN.

88. To date, CISWG has produced Standard Operating Procedures and a strategic framework on Critical Incident stress; a Critical Incident Stress Management Cell paper and guidelines on communication in crisis and non-crisis settings.

D. UN Cares

89. Established as an outcome of a coordinated UNMDWG/WHO project,[60] UN Cares is the system-wide workplace programme on HIV/AIDS that provides United Nations personnel and their families with access to information, learning opportunities, preventive commodities, post-exposure prophylaxis (treatment taken immediately after exposure to HIV in an effort to prevent infection). This is achieved through the implementation of the *UN Cares 10 Minimum Standards* that serve as a model of the United Nations reform process by "Delivering as One" and HIV workplace programme that builds on existing workplace efforts of various United Nations agencies, while eliminating duplication of effort.[61]

90. In operation since 2008 and funded by 21 International Organizations, UN Cares envisages that by 2013, participating organizations could incur combined savings close to USD 36 million.[62] These would be in the form of a reduction of funerary benefits, death benefits and recruitment and training costs for new workers required to replace those who are unable to work with AIDS.[63]

91. The Inspector notes that the current UN Cares programme budget (approved by HLCM) is funded on a 50% basis only to the tune of USD 2.6 million.[64] He noted that the UN Secretariat had not yet provided its contribution of USD 350,000 (though funds had been requested) for the 2010/2011 budget thought such a request had been made.[65] Furthermore, the Secretary-General has made UN Cares a priority, stating his determination to make the United Nations a model of how the workplace should respond to HIV.

---

[59] A/RES/57/155, 3 March 2003, para 21.

[60] See footnote 53.

[61] "Living in a world with HI – Information for UN system personnel and their families, UNAIDS, second revised reprint 2009. See also www.uncares.org.

[62] "UN Cares: The Programme on HIV in the UN System Workplace – Current Status 2010-2011 and Strategy Beyond 2011", CEB/2010/HLCM/HR/29, 28 June 2010.

[63] The Financial Impact of HIV and AIDS on the UN Workplace, www.uncares.org.

[64] UN Cares: The Programme on HIV in the UN System Workplace – Current Status 2010-2011 and Strategy Beyond 2011", CEB/2010/HLCM/HR/29, 28 June 2010.

[65] Ibid., p. 5.

92. While success of the UN Cares is dependent on the leadership and action of all participating members, the Inspector noted that contribution by all would permit the agreed external evaluation of the programme to be carried out in 2011.[66]

E. UN Plus

93. On the recommendation of the UN Cares Task Force, UN Plus was established in 2005 as part of the United Nations Reform in action with a mission statement "Uniting for Solidarity, equality and acceptance for people living with HIV within the United Nations system through awareness raising, policy change and advocacy."[67]

94. To achieve its stated objectives: (i) create a more enabling environment for all HIV-positive staff members, irrespective of the level of disclosure of their HIV status; (ii) create an organized and effective voice for people living with HIV within the United Nations system that challenges stigma and discrimination and (iii) contribute to the development and/or improvement of existing policies on HIV among United Nations agencies; 30 UN Plus members from 11 organizations met in 2006 and prepared position papers on challenges faced in four key areas: confidentiality; improving mobility and addressing travel restrictions; health Insurance and; reducing HIV-related stigma and discrimination.

95. These papers address the realities and needs of affected UN staff members and their immediate families as well as provide guidance for policy makers entrusted with implementing/modifying the 1991 United Nations Personnel Policy on HIV/AIDS to their respective organization's requirements.

---

[66] Ibid., p. 5.

[67] www.unplus.org.

V. TOWARDS A FUTURE SYSTEM-WIDE MEDICAL SERVICE/OCCUPATIONAL SAFETY AND HEALTH COORDINATION/COOPERATION MECHANISM

96. The adoption of OSH policies will require the centralization of distinct OSH services under one umbrella not only at the organizational level, but at the system-wide level as well, for effective coordination and implementation. This is particularly the case for the latter as current practice is hampered not only by the absence of a system-wide mechanism, but the fragmentation (lines of authority) of medical/OSH services provided by United Nations system organizations for staff is not conducive for service level optimization.

97. The Inspector wishes, through the example below, reiterate the necessity to have a system-wide body to coordinate/assume responsibility for a system-wide medical response.

98. The recent H1N1 influenza pandemic situation provided an important opportunity for the United Nations Medical Services to experience and assess the complex processes needed for a centralised system-wide procurement exercise for common medical supplies within the United Nations.

99. In September 2009, difficulty regarding access to the H1N1 vaccine by United Nations staff was discus-ed at the high level Steering Committee on Influenza chaired by the Deputy Secretary-General. At that time the United Nations found itself in a uniquely unfavourable situation, because of reduced yield by the candidate H1N1 vaccine viruses in eggs (resulting in massive underproduction of the vaccines by manufacturers), the already existing shortage of global vaccine manufacturing capacity, and huge bulk purchases made in advance by governments (accounting for all available and immediately prospective vaccine production quotas). *Only governmental or linked organizations were able to purchase the vaccines at that time*[68]. The Steering Committee on Influenza therefore decided that a way forward should be found to ensure that United Nations staff and dependents, particularly those in remote locations, had equitable access to the H1N1 vaccine.

100. From that first September meeting of the Steering Committee on Influenza, it was another three months before an agreed approach and way forward could be identified and formally endorsed. During this period, an *inter-Agency task force* considered issues such as legal liability, priority groups to access the vaccine, and mechanisms for central procurement, distribution and administration of the vaccine. *Following endorsement of a plan in December 2009*, another three months were needed to negotiate and finalize a Memorandum of Understanding between the United Nations Secretariat and UNICEF, who agreed to be the lead agency for procurement and worldwide distribution of the vaccine. The MOU was signed on 9 April 2010, but further delays occurred as *DPKO required another three months for redeployment of associated funds from their Missions back to UNHQ, and then transfer of these funds from UNHQ to UNICEF*. In fact, at the time of writing this report (November 2010), more than a year after the pandemic outbreak, efforts are still underway to acquire vaccine stocks and ship them to staff in some remote DPKO locations.

101. In the Inspector's view, the above constitutes an unacceptable delay, and there is clearly a strong need to improve the United Nations system's processes so that such long delays do not repeat again in the future, whether the need is related to medical supplies for another flu pandemic, natural disaster, or other medical emergency.

---

[68] H1N1 Influenza Vaccine: Global Access for a Global Problem. Noni Macdonald. Can. Med. Assoc. J. August 4, 2009; 181 (3-4) Available at http://ecmaj.com/cgi/content/full/181/3-4/123 and based on MSD's exploratory discussions with pharmaceutical companies, Nuria and Sanofi Aventis, at the time.

102. The above case highlights the need for a centralized, properly structured and funded procurement system for medical supplies, which would increase efficiencies of bulk purchase, reduce unnecessary and duplicated administration, and minimise such delays in the future. Designated buyers in Headquarters would be able to work directly with vendors to purchase medical supplies on behalf of United Nations entities, and effect immediate transfer of payment to vendors, as might be called for in a crisis. A centralized procurement system would provide a standardized, economical system for acquisition and distribution of commonly used medical supplies, for use by United Nations staff globally and reduction in administrative costs through elimination of multiple purchasing staffs, records and procedures.

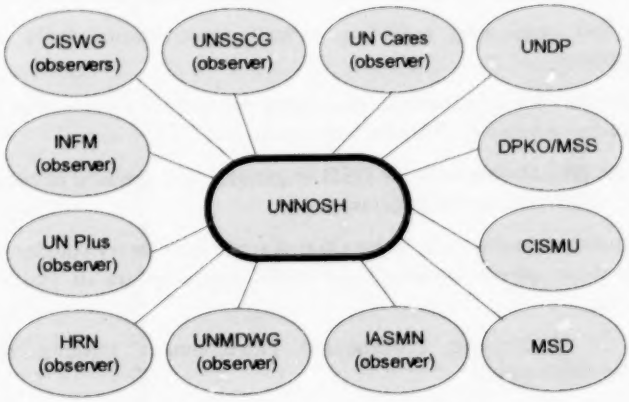
103. For security-related issues, the United Nations system established IASMN, which brings together senior managers of all partners in the United Nations security management system including agencies, funds and programs to coordinate security practices and policies across the United Nations system. **Thus for OSH-related issues, a similar network is required and the Secretary-General should submit a formal request to the General Assembly for its establishment.**

104. IASMN is also concerned with OSH issues and at their 2010 meeting in Nairobi strongly supported the cross-disciplinary initiative to "develop a comprehensive and well-managed relevant occupational health and safety framework for the United Nations system, and requested UNMDWG to provide an update on its progress to them at their next meeting."[69] UNMDWG is also aware that they must adapt their draft Medical Minimum Operating Standards to the concept and structure of Minimum Operating Security Standards (MOSS).[70] In furtherance of the above, the establishment of a coordinating body will be the enabling mechanism to achieve this goal.

105. The proposed new coordinating body, the United Nations Network on Occupational Safety and Health (UNNOSH), derived from the IASMN model, will support HLCM in its comprehensive review of policies and resource-related issues pertaining to the entire United Nations occupational safety and health structure, which is an important item on its agenda.

106. UNNOSH will bring together the senior managers who have managerial oversight of the occupational safety and health function within the following bodies listed in Figure 9 below:

Figure 9
Members of the proposed UNNOSH



[69] Para 89, Minutes of IASMN meeting held in Nairobi (1-5 February 2010).
[70] CEB/2009/HLCM/17, 18 February 2009, para 3.

UNNOSH should include all CEB member organizations, as well as those organizations that have concluded a Memorandum of Understanding with the United Nations for the purposes of participating in the United Nations OSH structure. It should also include United Nations Staff Federations (observer status) and any organization or department which has a specific mandate for management of the occupational safety and health of United Nations staff, personnel and premises or which are directly involved in the coordination, delivery and support of United Nations activities in the field especially during emergencies and in high-risk environments.

107. UNNOSH should monitor the implementation of United Nations OSH policies, practices and procedures by all actors of the United Nations system, including the related programme budget and report and make recommendations thereon to HLCM.

108. The implementation of the recommendations below will enhance coordination and cooperation as well accountability of the stakeholders.

Recommendation 7

The General Assembly should mandate the Secretary-General to create the United Nations Network on Occupational Safety and Health with a defined Term of Reference, and which should be headed by the United Nations Chief Medical Director.

109. The Inspector notes that with the expansion of UNNOSH-related matters and the fact that the lack of resources will impact its effectiveness, **strongly endorses** the creation of a small UNNOSH secretariat by the Secretary-General, consisting of one Professional and one General Service staff members within MSD.

110. The Inspector does not suggest that the existing system-wide mechanisms, e.g., UNMDWG, UNSSCG and CISWG be merged to UNNOSH, but rather that they continue with their present mandates and focus on their specific subject areas. Areas of overlap should therefore be discussed at UNNOSH.

111. As UNNOSH will be the first inter-agency policy making group to address system-wide OSH, it will have to address a wide range of issues, advising on policy and procedural guidelines as required. The indicative list below illustrates the magnitude of the task ahead, as well as the potential negative impact of continuing without systemic coordination and management of OSH:

- Guidance and monitoring regarding overall organizational OSH policies, and their implementation;
- Introduction of risk management principles for both environmental health and safety, and promotion of individual health and well-being;
- Guidance on ethical standards for OSH in general, and specific occupational sub-groups (e.g., doctors, nurses, counsellors etc);
- Issuing of professional standards for OSH practitioners (entry standards for employment, continuing development standards for maintenance/update of skills and professional certification);
- Provision of Continuing Professional Development training to achieve skills maintenance standards;
- Guidance for adjudication of professional disputes and/or challenges regarding ethical and professional standards of care;

- Development of healthcare facility standards (for facilities accessible by United Nations staff);
- Occupational and environmental standards for United Nations workplaces (e.g., ergonomics of workplace equipment, lighting, noise etc);
- Good practice guidelines for OSH facilities, including confidentiality issues, and standardization of electronic medical and healthcare record systems;
- Establishment of a decentralized management structure enabling development, support, oversight, and monitoring of a predominantly field-based OSH system;
- Recommendations regarding job descriptions, post levels, and career development for OSH staff members;
- Establishment of a reliable and responsive centralized procurement process for medical and healthcare supplies;
- Re-evaluation of historically provided medical procedures and services, with a view towards change to modern, preventive OSH (e.g., sick leave, medical clearance, etc);
- Evaluating and recommending outsourcing options to avoid conflicts of interest (e.g., simultaneous provision of healthcare, and adjudication of insurance benefits for staff);
- Improving pre-travel and pre-deployment risk assessment procedures, and individual preparedness and resilience for hardship missions;
- Reviewing and advising on organizational management of psycho-social health issues, including substance abuse;
- Providing system-wide guidance on emergency medical preparedness and response, including for pandemics, mass casualty incidents, and other public health emergencies;
- Coordinating a system-wide approach to medical evacuation;
- Reviewing and advising on medical aspects of organizational policies and approaches to HIV/AIDS;
- Reviewing, advising, and coordinating system-wide approach to compensation for service incurred injury and illness, disability benefits, and special benefits (e.g., special education grant and grants for disabled children).

ANNEXES

ANNEX I
Medical Services and Programmes Provided at headquarter duty stations (as of June 2010)

	Emergency/Primary Care	Vaccination	Travel Safety	Health Promotion	Certification Sick/Maternity Leave	Medical Clearance	Medical Examination	Entry Medical Examination	Periodic Medical Examination	First Aid Training	Welfare Office	Ergonomics	Stress Management	HIV/AIDS Counselling	Screening Programmes	Disability Assessment	Psychological/Social Assistance	Laboratory	Fitness Centre
ECA	x	x	x	x		x	x	x	x	x		x		x	x		x	x	x
ECLAC	x	x	x	x	x	x	x		x	x	x		x	x	x				
ESCAP	x	x	x	x	x	x	x							x					
ESCWA	x	x		x	x	x	x		x	x	x	x		x		x			
FAO	x	x	x	x	x		x	x	x	x	x	x		x	x		x		
ICAO	x	x	x		x			x	x							x			
ICTR	x	x	x	x	x														
ILO	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	
IMO	x	x		x		x							x	x	x				x
IOM	x	x	x	x			x			x		x	x	x					x
OPCW	x	x	x	x	x	x													
UNESCO	x	x	x	x	x		x	x	x	x	x	x			x	x			x
UNHCR	x	x	x	x	x	x	x	x	x	x	x	x	x						
UNHQ[1]	x	x	x	x	x	x	x	x		x	x	x	x			x	x	x	
UNOG[2]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	3x
UNON[3]	x		x		x	x	x	x	x		x								
UNOV[4]	x	x	x	x		x	x	x	x		x	x			x				
UNRWA						x		x	x										
WFP	x	x	x		x	x				x	x	x			x	x		x	
WHO	x	x	x	x	x	x	x	x	x	x		x	x	x			x	x	
World Bank	x	x	x	x	x	x	x				x	x	x	x	x			x	x
TOTAL	**20**	**19**	**18**	**17**	**16**	**16**	**15**	**14**	**14**	**13**	**13**	**12**	**11**	**11**	**11**	**10**	**10**	**8**	**8**

[1] UNHQ includes UNDP, UNICEF, UNFPA.
[2] UNOG includes ITU, WMO, WIPO, ECE, UNCTAD, ITC.
[3] UNON includes UNEP, UN-HABITAT.
[4] UNOV includes IAEA, UNIDO, UNODC, CTBTO.

ANNEX II
Services generally expected from on-site United Nations dispensaries

a) Primary Clinical Care to United Nations system personnel

(i) Provide first aid and emergency services in response to accidents occurring in the workplace;

(ii) Provide consultation and treatment for acute medical conditions for walk-in patients;

(iii) Continue management or assist in the follow-up of chronic medical conditions which are diagnosed and treatment has already started;

(iv) Provide necessary diagnostic tests required by clinical conditions, either onsite or through locally available laboratory;

(v) Facilitate staff access to local medical facilities and to ensure follow up.

b) Occupational Health Services

(i) Promote health of the staff, ensuring medical compatibility with job requirements;

(ii) Provide travel medical services for staff on official travel, incorporating destination specific health advice, immunization, prophylactic medications and travel medical kits;

(iii) Advise staff members regarding all medical and health issues related to their work;

(iv) Assess and respond to staff concerns regarding health and ergonomic aspects of their workplace and other matters related to work environment;

(v) Conduct preventive health and health promotion programs, i.e., blood pressure monitoring, screening of diabetes and smoke cessation;

(vi) Contribute to induction and other health-related training, i.e. first aid training, CPR, etc.;

(vii) Provide continuous support and assist in fully implementing "UN HIV/AIDS personnel policy" related activities and programmes.

c) Advisory Services to the management of all United Nations agencies

(i) Recommend and arrange for medical evacuation to the recognized regional medical evacuation centres;

(ii) Provide advice on sick leave issues;

(iii) Provide advice and assist on reasonable work accommodation for staff who are not able to carry out full-time or his/her regular duties for a specific period;

(iv) Provide medical advice for disability cases, special dependency, work related illness or injury and education benefits;

(v) Verify appropriateness, reasonableness and customary of medical bills.

d) Other services

(i) Organize periodic orientation sessions with all staff on the services provided by the United Nations Dispensary;

(ii) Produce and keep up-to-date a one page flyer with their mission and services, including contact information and hours of service;

(iii) Supply, replenish and up-date all medical kits to all duty stations within the country including medical kits for United Nations official vehicles;

(iv) Systematically access and liaise with local medical facilities; establish a referral list and keep it up-to-date.

Source: UN Dispensaries Draft, UNDP Office of Human Resources, Bureau of Management, 8 July 2009 update.

ANNEX III

Glossary of Level 1-4 United Nations Medical Facilities

- **Level 1 Medical Support Facility**

Level 1 medical support facility is the first level of medical care that provides primary health care, and immediate lifesaving and resuscitation services. It is the first level of medical care where a doctor/ physician is available. Capacity: provides treatment to 20 ambulatory patients/day, holding capacity of 5 patients up to 2 days, medical supplies and consumables for 60 days.

Composition: actual composition and number of Level I medical personnel may vary depending on the operational requirements, and agreed upon in the MOU; however, basic manpower proposal is (including the capability of splitting into 2 forward medical teams (FMT) - each with 1 doctor and 2-3 paramedics): 2 medical officers, 6 paramedic/nurses 3 support staff.

- **Level 1+ medical facility**

In accordance with specific mission requirements, a level 1 medical facility can be enhanced to level 1+ by the addition of supplementary capabilities that enhance the medical support facilities are reimbursed separately, in accordance with the COE Manual and the MOU. Examples of additional capabilities include:

- Primary dental care
- Preventive medicine
- Basic laboratory testing
- Aero-medical evacuation team
- Surgical capability (forward surgical module) — only in exceptional situations, dictated by the exigencies of medical service support, additional patient holding capacity and deployment should be based only on the requirements of the DPKO/DFS

- **Level 2 Medical Support Facility**

A level 2 medical support facility corresponds to the next level of medical care and the first level where basic surgical expertise is available, and life support services and basic hospital and ancillary services are provided within the mission area. A level 2 medical support facility provides all level 1 capabilities and, in addition, includes capabilities for: emergency surgery, life and limb saving surgery, post operative services and high dependency care, intensive care-resuscitation, and in-patient services; also basic imaging services, laboratory, pharmaceutical, preventive medicine and dental services are provided; patient record maintenance and tracking of evacuated patients are also minimum capabilities required for a level 2 medical support facility.

Capacity for 3-4 surgical operations/day, hospitalization of 10-20 sick or wounded up to 7 days, up to 40 outpatients/day, 5-10 dental consultations/day, medical supplies, fluids and consumables for 60 days.

Composition: actual composition and number of level II medical personnel may vary depending on the operational requirements, and agreed upon in the MOU; however, basic manpower proposal is: 2 surgeons (general and orthopaedic); 1 anaesthetist; 1 internist; 1 general physician; 1 dentist; 1 hygiene officer; 1 pharmacist; 2 head nurses; 2 intensive care nurses; 1 operational theatre assistant; 19 nurses/paramedic; 1 radiographer; 1 laboratory **technician; 1 dental assistant; 2 drivers; 8 support staff.**

- **Level 2+ medical facility**

The level 2 capability can be enhanced to level 2+ by augmentation with additional capabilities that enhance the medical support facilities are reimbursed separately, in accordance with the COE Manual and MOU. Examples of additional capabilities include:

- Orthopaedic capability
- Gynaecology capability
- Additional internal medicine capability
- Additional diagnostic imaging capability (CT scan)

A level 2 or 2+ medical facility may be a contribution of a troop/police contributor, a United Nations owned-medical facility, or commercially contracted.

- **Level 3 medical support facility**

A level 3 medical support facility corresponds to the third and the highest level of medical care deployed within a mission area. At this level all capabilities of a level 1 and 2 medical support facility are provided and, in addition, capabilities for: multi-disciplinary surgical services, specialist services and specialist diagnostic services, increased high dependency care capacity and extended intensive care services, specialist outpatient services, maxilo-facial surgery.

- **Level 4**

This facility is the highest level of facility provides definitive medical care and specialist treatment in all fields of surgery and medicine.

Source: MSD

ANNEX IV
Medical Support Section core functions

A. Advisory

- Advise DPKO/DFS, DPA and field missions on all medical support planning and Logistics matters
- Develop medical support policies, doctrine and guidelines

B. Coordination

- Plan and coordinate medical logistic component of UN global medical support in collaboration with UNHQ departments, TCCs and UN Agencies, for new, ongoing and liquidating missions

C. Medical Support Planning for Field missions

- Participation in technical Assessments and Evaluation of field missions
- Develop medical Support concept
- Develop medical Support plan
- Develop and review of Standard operating procedures and Guidelines
- Pre-Deployment medical assessment for TCCs and PCCs
- Briefing of TCCs and PCCs and medical requirements
- MOU/LOA negotiations
- Implementation of medical support plan
- Assessment of medical facilities in start-up, on-going and liquidating missions
- MSS Desk Officers at UNHQ provide oversight to missions in the implementation of the medical support plan

D. Medical Logistics

- Missions Budgeting and Finance for medical support
- Develop Material Resource Plan (MRP)
- Develop Material Acquisition Plan (MAP)
- Management of Strategic Deployment Stock (SDS)
- Management of Strategic Deployment Stock (SDS)
- Management of mission medical assets for start-up, ongoing and liquidating phases
- Develop Material Disposition Plans
- Provide briefing on medical support matters to Director LSD
- Provide medical support component in Strategic planning exercises i.e. DFS Global field Support Strategy, Benchmarking Study, Roadmap for medical data reporting from missions, Service Delivery Module of ERP etc.
- Review and proffer solutions to Director LSD for medical aspects of Board of Inquiry recommendations

E. Procurement

- Develop Technical Specifications and Statement of Requirements (SOR)s for medical equipment, consumable, drugs and pharmaceuticals, and blood and blood products
- Develop SORs for Commercial Medical Services
- Management of UNHQ global contract for medical services
- Oversight role in mission local procurement

F. Training

- Medical personnel in medical planning and management of medical resources
- Conducting Chief medical Officers Annual Workshop

Source: MSS response to Inspector's questionnaire.

ANNEX V

Overview of action to be taken by participating organizations on JIU recommendations

JIU/REP/2011/XX

		Intended impact	United Nations, its funds and programmes												Specialized agencies and IAEA												
			United Nations*	UNCTAD	UNODC/UNOV	UNEP	UN-HABITAT	UNHCR	UNRWA	UNDP	UNFPA	UNICEF	WFP	(OTHERS)	ILO	FAO	UNESCO	ICAO	WHO	UPU	ITU	WMO	IMO	WIPO	UNIDO	UNWTO	IAEA
Report	For action		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☒	☒	☒	☒	☐	☒	☒	☒	☒	☒	☒	☒	☒
	For information		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐
Recommendation 1		g	E	E	E	E	E	E	E	E	E	E	E		E	E	E	E		E	E	E		E	E	E	E
Recommendation 2		g	L	L	L	L	L	L	L	L	L	L	L		L	L	L	L		L	L	L		L	L	L	L
Recommendation 3		b	E		E	E	E	E	E						E		E	E		E			E		E	E	E
Recommendation 4		a	E							E																	
Recommendation 5		e	E																								
Recommendation 6		d	E																								
Recommendation 7		c	L																								

Legend: L: Recommendation for decision by legislative organ **E:** Recommendation for action by executive head

Recommendation does not require action by this organization

Intended impact: a: enhanced accountability **b:** dissemination of best practices **c:** enhanced coordination and cooperation **d:** enhanced controls and compliance **e:** enhanced effectiveness **f:** significant financial savings **g:** enhanced efficiency **o:** others